Employment History Affidavit for Claim Under the Energy Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Note: This form is used to affirm the employment history of a living or deceased individual who incurred a designated illness as a result of their exposure to radiation, beryllium, or silica while in the performance of duty for the Department of Energy and certain of its vendors, contractors, and subcontractors.

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OMB No. 1215-0197

Expiration Date: 8/31/2007

NAME OF THE PERSON COMPLETING AFFIDAVIT:

Print Full Name	
Street Address	
City, State, Zip Code	

AFFIRMING THE EMPLOYMENT HISTORY OF THE FOLLOWING PERSON:

Print Full Name	
Maiden/Former Name	
Social Security Number (If known)	

RELATIONSHIP BETWEEN PERSON COMPLETING AFFIDAVIT AND EMPLOYEE:

☐ **Spouse** ☐ **Son/Daughter** ☐ **Parent** ☐ **Grandparent**

☐ **Friend** ☐ **Work Associate** ☐ **Other**

EMPLOYEE'S WORK HISTORY:

In chronological order, starting with the most recent period of employment, describe your knowledge of the employee's work history. Provide as much identifying information as possible concerning the name of the employer and location (city & state) where work was performed.

Employer 1

Dates of Employment	Start Date	End Date
Employer name and work site location		
Describe the type of work performed		
Explain how you know the employee worked for this employer		

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Employer 2

Dates of Employment	Start Date	End Date
Employer name and work site location		
Describe the type of work performed		
Explain how you know the employee worked for this employer		

Employer3

Dates of Employment	Start Date	End Date
Employer name and work site location		
Describe the type of work performed		
Explain how you know the employee worked for this employer		

Employer4

Dates of Employment	Start Date	End Date
Employer name and work site location		
Describe the type of work performed		
Explain how you know the employee worked for this employer		

DECLARATION OF PERSON COMPLETING FORM

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided under the EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I affirm that the information provided on this form is accurate and true.

Signature _____ Date _____

Contact Phone Number _____

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FORM EE-4

This form is used to affirm the employment history of a living or deceased Energy employee. The EE-4 is an acceptable format for providing an affidavit in support of an otherwise unsupported work history and can be filled out by anyone with knowledge of a covered employee's work history. Use as many EE-4 forms as needed. If you require additional space to provide comments, attach a signed supplemental statement.

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 et seq.) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the Debt Collection Act. (6) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision. This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the EEOICPA.

PUBLIC BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim to this address. Completed claims are to be submitted to the appropriate district office of the Office of Workers' Compensation Programs. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.